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No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1992

JONATHAN MARSH, a minor,
by and through his Guardian
Ad Litem, Sharon Marsh,

Plaintiff-Petitioner,

v.

ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,

Defendant-Respondent.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS FOR REVIEW

1. What rules of contract interpretation should be applied to construction of insurance policies issued to employee welfare benefit plans for medical insurance benefits under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. section 1001, et seq.?

2. Does the doctrine of vesting of benefits apply where the insurance policy language supports application of that doctrine in the interpretation of medical insurance policies subject to ERISA?

3. Where an insurer providing medical insurance coverage to an employee

benefit plan fails to inform the beneficiaries of the plan that the conversion policy offered under the policy has significantly reduced benefits, is the insurer obligated to issue a conversion policy with benefits equivalent to the terminated group insurance coverage?

PARTIES TO THE PROCEEDING

Plaintiff and Petitioner:

JONATHAN MARSH, by and through his Guardian ad Litem, Sharon Marsh

Defendant and Respondent:

ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK

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STATEMENT OF GROUNDS FOR JURISDICTION

The Memorandum order of the United States Court of Appeals for the Ninth Circuit which is sought to be reviewed was issued on January 22, 1992. (See Appendix, Tab A.)

A petition for rehearing was timely filed by plaintiff/appellant on February 7, 1992.

The United States Court of Appeals for the Ninth Circuit issued its denial of the petition for rehearing on March 17, 1993. (See Appendix, Tab B.)

This honorable Court has jurisdiction to review the judgment by writ of certiorari under 28 U.S.C. section 1254.

This action arises under 29 U.S.C. section 1001, et seq., the Employee

Retirement Income Security Act ("ERISA"). The ERISA statutes are included within the Appendix at Tab C.

STATEMENT OF THE CASE

ERISA, and its application, affects millions of Americans who receive their health and medical insurance benefits through employment. This action presents critically important questions of how insurance policies issued by insurance companies to employee benefit plans are to be interpreted and construed.[1]

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[1] This honorable Court's opinion in FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403 (1990), made clear that the rules to be applied to ERISA plans which are self-funded may not necessarily be the same as those applied to plans underwritten by the actual purchase of insurance. This case presents the argument that the special rules of contract construction in regard to insurance policies should be applied, at the very least, to underwritten plans. It is an issue for another case as to whether those same special construction rules should be applied to self-funded plans.

JONATHAN MARSH, now 14 years old, suffered anoxic brain damage as the result of a swimming pool accident in October, 1982 when he was four years old. Since that accident, MARSH has remained in a persistent vegetative state and is plagued by frequent seizures, electrolyte instability and cardiopulmonary compromise. As the result of his condition, MARSH is completely dependent on home health care nurses to provide him with care, treatment and medical assistance.

On the day of his drowning accident, MARSH was insured under a group insurance policy issued to his father's employer, Universal Broadcasting, for major medical and health insurance. The policy was underwritten by The Equitable Life

Assurance Society of the United States. In January, 1984, the Equitable policy was terminated and the underwriting of the plan was assumed by The Travelers Insurance Company. The Travelers policy was, in turn, terminated and the group policy was then underwritten by ALLSTATE.

ALLSTATE, like its predecessors, provided coverage for major medical health costs and expenses. While insured under the ALLSTATE policy, MARSH's father left his employment with Universal Broadcasting, but elected to maintain the ALLSTATE coverage under his COBRA rights. On or about May 1, 1989, however, ALLSTATE unilaterally terminated the group coverage. ALLSTATE offered to extend the benefits available under the group insurance policy for one

calendar year from the date of termination of that policy. Upon the threatened termination of that extension of benefits, MARSH filed a complaint in the United States District Court seeking declaratory relief, damages for breach of fiduciary duty and injunctive relief. An Application for Temporary Restraining Order was filed in the action and a Temporary Restraining Order was issued by the District Court. After briefing and hearing on the motion for preliminary injunction, the District Court determined that the ALLSTATE policy was ambiguous in regard to continued coverage for a loss which arose prior to termination of the policy and issued its preliminary injunction prohibiting ALLSTATE from terminating MARSH's nursing care benefits. (See

Appendix, Tab D.)

At argument on the preliminary injunction, Judge Bonner recommended that the action be resolved by way of cross-summary judgment motions. Inexplicably, in ruling on the cross-summary judgment motions, Judge Bonner completely reversed his prior findings on the preliminary injunction and ruled that the ALLSTATE policy was not ambiguous and did not provide continuing coverage. (Appendix, Tab E.) The District Court then denied MARSH's summary judgment motion, granted ALLSTATE's motion and dissolved the preliminary injunction. (Appendix, Tab E.)

This appeal involves the doctrine of "vesting". Care must be taken, however, to refrain from importing more

into that phrase than is justified under the circumstances. It is not a magical incantation used in an attempt to impose unjustified duties on an insurer.

"Vesting", as applied to this case, is nothing more than a shorthand phrase for a circumstance where an insurance policy, either by its express terms or *as the result of an ambiguity in its terms*, provides continuing coverage after the termination of the policy for a loss which arose before the termination of the insurance policy. Under the doctrine of vesting, where an injury or illness arises before the termination of the medical insurance policy, the policy provides for continuing treatment for only *that* injury or illness even after the termination of the policy for purposes

of any other injury or illness.

The ALLSTATE policy specifically states that "[t]he end of insurance will not affect any claim made for a *loss* that took place while the insurance was in force." (Emphasis added.) As ALLSTATE itself admitted in its Opposition to the Preliminary Injunction, this is a classic "vesting" provision. Thus, the policy expressly provides that the termination of the insurance policy does not affect the insured's right to continuing insurance for a *loss* that arose prior to the termination.

ALLSTATE argued below, and the District Court and the appellate court ruled, however, that despite this express statement of continuing benefits, the portions of the policy

which deal with the payment of "Eligible Expenses" for medical treatment require that the expenses for treatment, to be covered, must be incurred "while insured". Both the District Court and the Ninth Circuit Court of Appeals concluded that if the expense was incurred after the termination of the policy, there was no coverage. But this ignores the language of the termination provision which provides that so long as a "loss" occurred prior to termination, "*coverage*" for that "loss" still exists and expenses for treatment incurred for that "loss" are incurred while "coverage" for that "loss" is still in effect.

The Ninth Circuit reasoned that because the "Eligible Expenses" provision could be read in harmony with

the termination provision to support the conclusion that all benefits and coverage terminated upon the termination of the policy itself, there was no ambiguity and MARSH was not entitled to further benefits.

However, the appellate court's analysis does not take into account the "*contra proferentem*" rule of contract construction which is uniformly applied by common law courts, particularly in the context of insurance policy construction. In this case, the two contract provisions can reasonably be construed either to provide coverage or to exclude coverage. The strongest evidence of this is the fact that the District Court did just that. Upon motion for preliminary injunction, the District Court determined that vesting

applied under a reasonable construction of the policy provisions and upon motion for summary judgment determined that a reasonable construction of the policy provisions resulted in termination of benefits.

The appellate court overlooked the obvious. The insuring provision portion of the policy provides that insurance continues as to the "vested" condition despite the termination of the policy. The "Eligible Expense" provision of the medical insurance portion of the policy only requires that the expense be incurred "while insured". As long as the expense is incurred for treatment of the vested condition, the insurance is still continuing for that condition and the insured incurs the expense while insured.

ALLSTATE wrote the policy. Had it intended to require that the medical expense be incurred during the term of the policy rather than during the term of the insurance coverage, it could have stated that. ALLSTATE need only have stated that an expense, to be covered, must be incurred prior to termination of the policy. This is the logical way to state the condition. But ALLSTATE did not do that. Rather, ALLSTATE keyed the coverage to the existence of "insurance" rather than to the effective date of the policy.

Even were ALLSTATE's argument that the "Eligible Expense" definition required the expense to be incurred during the policy term (as opposed to being incurred "while insured"), the promise that the termination of the

policy would not affect any claim for a loss which took place while the insurance was in force creates a core conflict and ambiguity.

The District Court and the appellate court, in construing the policy failed to apply rules of construction which favored the insured beneficiary. Given the important public policy considerations in regard to insurance and ERISA in general, it is critically important to establish federal common law rules for interpretation and construction of insurance policies issued to employee welfare benefit plans so that ERISA's express purpose in safeguarding employee benefits can be fulfilled and implemented.

In turn, application of contract

construction rules developed in general insurance law require the application of the vesting doctrine in this case. Similarly, those rules and proper application of public policy requires that the conversion policy promised in the group policy provide benefits equivalent to those of the group policy absent a clear and express limitation or notification in the group policy that any conversion benefits will be limited.

These are issues of vital importance to the millions of Americans who obtain their medical insurance through their employment. These are also issues as to which there are numerous and conflicting resolutions throughout the Circuit Courts of Appeal. As such, this Court should grant certiorari in this case in order to

delineate the rules of construction and interpretation of insurance policies issued to ERISA plans.

ARGUMENT

A.

COMMON LAW RULES OF ADHESION CONTRACT INTERPRETATION SHOULD BE ADOPTED AS THE FEDERAL RULE FOR INTERPRETATION AND CONSTRUCTION OF INSURANCE POLICIES ISSUED TO EMPLOYEE WELFARE BENEFIT PLANS

There is currently much heated debate in the legal literature about whether the common law rule of construing any ambiguities against the

drafter of an adhesion contract should be applied in the context of ERISA plans. In its amended opinion, the Ninth Circuit Court of Appeals in Kunin v. Benefit Trust Life Ins. Co., 898 F.2d 1421 (9th Cir. 1990), amended, 910 F.2d 534, held that the rule that ambiguities should be construed against the insurer (the rule of *contra proferentum*) should apply to insurance policies issued to ERISA plans. Although some commentators have attempted to construe the Kunin rationale as being much broader than it is, it was made clear in Evans v. Safeco Life Ins. Co., 916 F.2d 1437 (9th Cir. 1990), that the state common law rule of construction is not adopted into ERISA law on the rationale that the rule of construction is saved from preemption. Rather, under Evans, insurance policies

issued to ERISA plans are to be interpreted under the uniform body of federal law. The issue which remains unresolved by the Ninth Circuit Court after Evans is whether the rule of *contra proferentum* is, or should be, part of the uniform federal common law which is to be applied to the interpretation of insurance policies issued to ERISA plans.

It is clear from the discussion in Kunin and from Justice Schroeder's dissent in Evans that this rule should reasonably form a part of the federal common law used to interpret insurance policies which are purchased by ERISA plans. To do otherwise would be to undermine the very purpose of ERISA.

Congress enacted ERISA to address particular social problems. Of specific

concern was the widespread abuse by the fiduciaries of employee pension plans. Underfunded pension plans, irresponsible fiduciaries, and a generally depressed economic environment contributed to the likelihood that many employees might be unable to obtain pension benefits even as the entire work forced aged and the fiscal solvency of the Social Security system became more and more precarious. (See generally, 29 U.S.C. section 1144; H.R. Rep. No. 807, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4670, 4678-9, 4680 ("House Report No. 807"); S. Rep. No. 383, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4899 ("Senate Report No. 383").

ERISA's purpose was to establish standards of conduct, to set forth the

obligation of employee benefit plan fiduciaries and to provide "appropriate remedies, sanctions, and ready access to the federal courts" for the failure of a plan fiduciary to live up to its responsibilities under ERISA. (Public Law 93-0406, as codified at 29 U.S.C. section 1001-1461 (1982) section 2(b). As was explained by the United States Supreme Court in its recent decision in Massachusetts v. Morash,109 S.Ct. 1668, 104 L.Ed.2d 98 (1989):

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from the accumulated funds. [Citation.] To that

> end, it has established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

Thus, ERISA's purpose is to protect the beneficiary. Its purpose is not to protect the employer or the insurance company. A rule which would work to permit an insurer to interpret and apply an ambiguous policy term in its own favor, just as the appellate court did in this case, defeats ERISA's express purpose of protecting the beneficiary. Indeed, how better to protect the

beneficiary's interests than to apply a rule that ambiguities in the insurance contract must be interpreted in favor of the beneficiary?

This rule will not defeat the goal of uniformity in decisions in ERISA cases. Given the broad range of plans, policies and myriad benefits and coverages available under the plethora of group insurance policies available, there is simply no way to assure uniformity of benefits. Indeed, ERISA does not mandate uniformity of benefits. The goal, instead, should be uniformity of *interpretation*. That can best be achieved by adoption and application of uniform insurance contract construction rules.

Thus, irrespective of the particular policy provisions, as to

which there is no possibility of uniformity, the rules to be applied to interpret those provisions will be uniform.

As noted by the Ninth Circuit Court in Kunin, every state in the Union uses and applies the rule of *contra proferentum* in interpreting insurance policies. Accordingly, the rule of *contra proferentum* should be adopted and applied in all cases in which contract interpretation is necessary and a non-negotiated insurance contract is in issue.

However, as evidenced by the Ninth Circuit's own conflicting opinions in Kunin and Evans, the lower courts are in disarray and disagreement about what rules should be applied. It is therefore necessary that this honorable

Court examine this question and determine the proper rules of construction and interpretation to be applied to insurance policies issued to employee welfare benefit plans.

B.

WHERE THE CONTRACT TERMS SUPPORT THE APPLICATION OF VESTING OF BENEFITS, ERISA PROPERLY PERMITS SUCH VESTING IN THE CONTEXT OF MEDICAL INSURANCE BENEFITS UNDER AN EMPLOYEE WELFARE BENEFIT PLAN

Vesting of medical and health insurance benefits has been adopted as a rule of law in numerous states, including Arizona (Sparks v. Republic National Life Ins. Co., 132 Arizona 529,

647 P.2d 1127 (1982)), **New York** (Danzig v. Dikman, 78 A.D.2d 303, 434 N.Y.S.2d 217 (1980), aff'd., 53 N.Y.2d 926, 423 N.E.2d 402, 440 N.Y.S.2d 925 (1981)), **Oregon** (Myers v. Kitsap Physicians Services, 78 Wash.2d 286, 474 P.2d 109 (1970)), **Alabama** (Blue Cross-Blue Shield of Alabama v. Turner, 280 Ala. 714, 195 So.2d 807 (1967)), **Arkansas** (Branscum v. Service Life Ins. Co., 234 Ark. 463, 352 S.W.2d 586 (1962)), **Mississippi** (Brown v. Blue Cross & Blue Shield of Mississippi, 427 So.2d 139 (1983)), **Missouri** (Lutsky v. Blue Cross Hospital Service, Inc., 695 S.W.2d 870 (1985)), **Montana** (Wardlow v. Kalispell General Hospital, 164 Mont. 59, 518 P.2d 1164 (1974); Fassio v. Montana Physicians' Service, 170 Mont. 320, 553 P.2d 998 (1976)), **New Mexico** (Erwin v. Limited

Benefit Life Ins. Co., 70 N.M. 138, 371 P.2d 791, (1962)), and Texas (Washer v. Continental Casualty Co., 418 S.W.2d 900 (1967), and Fields v. Blue Shield of Calif., 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), reh'g denied October 21, 1985.

For example, in Myers v. Kitsap Physicians Services, 78 Wash.2d 286, 474 P.2d 109 (1970), the insured under a group health care services contract suffered a chronic kidney disorder which required hospital hemodialysis treatments. The health care services company modified the health care contract under which the plaintiff was covered to exclude chronic kidney disorder treatments from coverage. The Washington Supreme Court stated:

"'We therefore conclude that

the contract before us, when considered for the purpose of granting or rejecting plaintiff's claim for hemodialysis hospitalization benefits . . ., may reasonably be given more than one interpretation. Although the contract is a health service contract, one reasonable interpretation of its provisions would be grounded on the same legal principle applied generally in cases relating to health and accident policies, i.e., that plaintiff's rights under the contract became vested when medical treatment became necessary. Those rights being

vested, the subsequent termination of the policy which created the right did not terminate the vested right of the plaintiff to payment of services rendered and to be rendered. (Fields, supra, 163 Cal.App.3d at 588, 209 Cal.Rptr. at 791-792; emphasis added by Fields court.)'"

Adoption of the vesting rule in the context of ERISA plans as part of the federal common law comports with state law and helps effectuate the policy concerns underlying ERISA. Where an employer, as part of an ERISA welfare benefit plan, purchases an insurance policy and the employer, through mismanagement of funds or otherwise,

causes termination of the plan, the employee can at least be protected for existing conditions up to the policy limit.

In the court below, ALLSTATE argued that, even if the policy supported the application of the vesting doctrine, vesting could not be applied to an employee welfare benefit plan. ALLSTATE argued that while ERISA expressly provides for vesting of benefits under pension plans, no such provisions were included under the welfare benefit plan provisions. This, ALLSTATE concluded, requires a finding that no vesting of benefits is authorized under ERISA.

This argument is flawed. The fact that ERISA does not require vesting of benefits clearly does not justify the conclusion that it therefore precludes

vesting of benefits. Although ERISA is a comprehensive statute, in terms of disclosure and regulatory rules, it simply does not mandate the type or extent of employee welfare benefits which must be provided. Indeed, ERISA does not require that any benefits be provided at all. It simply steps in to make sure that, when benefits are provided, they are provided in such a way as to protect the best interests of the beneficiaries.

By its very nature, the provision of employee benefits, especially medical insurance benefits, varies from employer to employer. ERISA does not require uniformity of benefits. Rather, the benefits are determined by the terms of the individual plan and/or the insurance policy purchased to provide the plan

benefits. Thus, ERISA's provisions are not determinative of whether vesting of benefits is applicable. Instead, the individual contract is determinative of that issue.

The same argument presented by ALLSTATE in this case was raised by the defendant in International Resources, Inc. v. New York Life, 950 F.2d 294 (6th Cir. 1991):

> "Finally, we come to a matter not addressed by the district court though raised by the parties on appeal. That is, whether or not the plaintiffs' rights have "vested" for the purpose of bringing the instant claims. We have held that pension plans are subject to statutory vesting

requirements under 29 U.S.C. §1053, although welfare plans are not. Armistead v. Vernitron, 944 F.2d 1287, 1297 (6th Cir. 1991). New York Life would have us believe that a welfare plan will never vest, because there is no statutory vesting requirement, or that such a welfare plan can only vest if it has explicit provisions providing for vesting in the plan documents. New York Life, however, misstates the law of In re White Farm Equipment Co., 788 F.2d 1186, 1193 (6th Cir. 1986). There, we found that we will not construe ERISA as providing a mandatory

point for welfare benefits to vest. Nonetheless, a court may look to the parties' intent to determine when vesting should occur. Such intent may be demonstrated by 'agreement or by private design.' Id. See also Armistead, at 1297-98. There may be sufficient evidence for the district court to find plaintiffs' claims have vested." (International Resources, supra, 950 F.2d at 301.)

As determined by the International Resources court, medical benefits may vest even though there are no mandatory vesting requirements under ERISA itself

and even where there is no express vesting provision in the policy. Thus, the issue of whether the benefits vest becomes inextricably intertwined with the determination of which rules of contract construction are to be applied. If standard contract rules, where ambiguity does not penalize the drafter, are applied, there may be no vesting. If, however, the adhesion contract rules normally applied in the insurance policy context are utilized, the policy at issue in this case clearly requires vesting of benefits.

It is not evident on the face of the appellate court's opinion what rule of construction it applied. However, the court determined that because the "Eligible Expenses" provision and the termination provision could be

harmonized and reasonably construed to preclude vesting, there would be no vesting. However, this conclusion ignores the fact that those provisions could also be harmonized and reasonably construed to provide vesting. If the adhesion rules of contract construction are applied to the insurance policy issued to an ERISA employee welfare benefit plan, MARSH is entitled to his vested benefits under the ALLSTATE policy and the appellate court erred.

Again, these are issues that will affect millions of Americans. There is already a crisis in the provision of health care to Americans. Every case which fails to protect the interests of the insured in an underwritten employee welfare benefit plan furthers the crises and sacrifices the health of covered

Americans to the interests of insurance companies garnering excessive profits. These issues must be addressed.

C.

HAVING FAILED TO NOTIFY THE BENEFICIARIES OF THE PLAN THAT CONVERSION BENEFITS WERE SIGNIFICANTLY REDUCED FROM THE GROUP POLICY, ALLSTATE IS REQUIRED TO PROVIDE EQUIVALENT BENEFITS UNDER THE CONVERSION POLICY

Another issue derivative of the issue as to which contract construction rules should apply is the question of what level of benefits MARSH was entitled to when the underlying group policy terminated and he sought to

purchase conversion coverage offered as an express benefit under the terms of the group policy.

The ALLSTATE policy at issue in this action expressly provides that, upon termination of coverage under the policy, the insured may apply for, and purchase, an individual conversion policy. When MARSH's father, who was the president of the company and the person responsible for choosing the insurance coverage, first obtained coverage under the ALLSTATE policy, the policy was silent as to the extent or amount of benefits to be provided under the conversion policy. Obviously, the extent of or the amount of conversion benefits would be important to any policyholder when deciding whether to procure a contract of insurance. The

absence of information concerning the conversion benefits when the policy is purchased is critical, since most policyholders will have no opportunity to shop the policy when the conversion rights are later needed.

When MARSH needed to convert from a group to an individual policy, he was virtually uninsurable under any other plan as a result of his catastrophic injury and disability. Thus, although MARSH's father may have been informed of the rights MARSH had under the conversion policy <u>after</u> the termination of the ALLSTATE group policy, he was, at that time, a captive purchaser who could only decide to take the conversion policy in the form offered by ALLSTATE or go completely uninsured. When the information concerning the rights and

benefits available under the conversion policy was finally made known to MARSH and his parents, that information was useless to them since MARSH had no alternative but to take the conversion policy despite its limited offerings.

A simple caveat placed within the policy language indicating that the rights under the conversion policy were substantially less than the rights under the group policy would have clarified the benefits offered under the conversion policy at the outset. In Sur v. Glidden-Durkee, a division of S.C.M. Corp. 681 F.2d 490 (7th Cir. 1982) (cited by defendant ALLSTATE in its Motion for Summary Judgment), the court was presented with facts substantially similar to those presented in the instant action. There, the policy was

silent as to the benefits afforded under the conversion policy stating only that the conversion policy was "subject to established rules". The Sur court stated:

> "This provision does not affirmatively state that the conversion policy will carry the same coverage as the group policy; but that fact alone does not make the provision not misleading. We must examine the provision in its entirety, and in the context in which it appears, to determine whether a rational trier of fact could find it misleading." Id.

In the instant action, the

conversion policy merely made reference to the benefits required by applicable law. Yet, reference to applicable law is virtually meaningless to a policyholder who lacks the legal sophistication and acumen that the drafter of the ALLSTATE policy possessed. Additionally, once the policy is issued to an employer, the question becomes whether individual state law regarding conversion rights constitute the "applicable law" or whether, under ERISA, federal law controls the content of the conversion policy. Naturally, absent any notice to the contrary in the policy, the insured would most reasonably expect that the same level of coverage as provided in the group policy would be provided in the conversion policy. Applicable law

does not change that result.

If it is determined that solely federal law is controlling, there are no limitations, either maximum or minimum on the type or extent of benefits which must be provided. Alternatively, state law provisions most commonly provide minimum benefits which must be provided but do not specify any maximum benefit level. Thus, under either federal or state law, the insured would reasonably expect the same level of coverage as provided in the group policy, absent some disclosure in the policy.

It is not argued that it was necessary for ALLSTATE to spell out in detail the benefits available under the conversion policy. However, ALLSTATE should have at least warned the policyholder that the benefits available

under the conversion policy would be substantially less than benefits available under the previous group policy.

MARSH detrimentally relied on the implicit promise of equivalent benefits. MARSH's father left his employment with Universal Broadcasters and elected to invoke his COBRA rights to continue coverage under the ALLSTATE policy for an 18-month period. However, prior to the expiration of that 18-month period, MARSH's father, believing that the conversion policy provided substantially similar benefits, terminated his COBRA participation and elected to proceed under the conversion policy. Had MARSH's father known that the conversion policy offered such drastically reduced benefits he simply would not have

surrendered his substantial COBRA rights.

Since ALLSTATE failed to inform the plan beneficiaries that the benefits available under a conversion policy would be substantially less than those under the group policy, ALLSTATE should provide substantially similar benefits under the conversion policy. Anything less constitutes a fraudulent business practice which should not be condoned by this Court.

CONCLUSION

This Court's review and determination of the proper and appropriate rules of construction to be applied to the interpretation and application of insurance policies issued to employee welfare benefit plans is vital. Although uniform benefits are not required or mandated under ERISA, common sense requires that a uniform system of policy interpretation be established. That determination should be made by this Court so that American citizens, who exchange the sweat of

their brow for the insurance protections provided by their employers, can be protected and assured of the benefits they work so hard to obtain.

Respectfully submitted,

Dated this 14th day of June, 1993 at Claremont, California.

SHERNOFF, BIDART & DARRAS

By: _____
WILLIAM M. SHERNOFF
Attorneys for Plaintiff and Petitioner

APPENDIX

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APPENDIX A

No. 90-56143

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

MEMORANDUM*

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

Appeal from the United States District Court for the Central District of California, Robert C. Bonner, District Judge, Presiding, Argued and Submitted May 8, 1991, Pasadena California

Before: BEEZER, HALL, and TROTT, Circuit Judges.

Appellant Jonathan Marsh appeals from the district court's grant of summary judgment to Appellee Allstate in March's suit to obtain continuing medical benefits under a policy terminated by Allstate. The district court had jurisdiction under 28 U.S.C. §1331 and 29 U.S.C. §1132(e). This court has jurisdiction pursuant to 28 U.S.C. §1291. We affirm.

I

In Evans v. Safeco Life Ins. Co., 916 F.2d 1437, 1441 (9th Cir. 1990), this court held that the interpretation of ERISA insurance policies is governed

by a "uniform federal common law." In developing a federal common law to govern ERISA suits, federal courts should borrow "from state law where appropriate, and [be] guided by the policies expressed in ERISA and other federal labor laws." Scott v. Gulf Oil Corp., 754 F.2d 1499, 1502 (9th Cir. 1985).

II

This court reviews a district court's grant of summary judgment de novo. International Brotherhood of Electrical Workers, Local 47 v. Southern Cal. Edison Co., 880 F.2d 104, 105 (9th Cir. 1989). In doing so, it must determine whether, viewing the evidence in the light most favorable to the party against whom summary judgment has been

granted, there is any issue of material fact and whether the moving party is entitled to judgment as a matter of law. Arizona Laborers Local 395 Health and Welfare Trust Fund v. Conquer Cartage Co., 753 F.2d 1513, 1515 (9th Cir. 1985). "When the meaning of an agreement is ambiguous on its face and contrary inferences as to intent are possible, an issue of material fact exists for which summary judgment ordinarily is inappropriate." International Brotherhood of Electrical Workers, 880 F.2d at 107 (citing Arizona Laborers, 753 F.2d at 1517-18).

III

In determining whether or not an insurance contract is ambiguous, this court will interpret its terms "'in an

ordinary and popular sense as would a [person] of average intelligence and experience.'" Evans, 916 F.2d at 1441 (quoting Allstate Insurance Co. v. Ellison, 757 F.2d 1042, 1044, (9th Cir. 1985)). The court should "examine[] the contract as a whole and if, on the face of the contract, two reasonable and fair interpretations are possible, an ambiguity exists." Evanston Insurance Company v. Fred A. Tucker & Co., Inc., 872 F.2d 278, 279 (9th Cir. 1979). The court will "'not create ambiguity where none exists.'" Evans, 916 F.2d at 1441. And if "'a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.'" Id.

There is no doubt that there is a reasonable interpretation of the Policy that favors Allstate. The Policy includes a broad description of the expenses it covers that cannot be interpreted to include expenses incurred after the Policy is terminated. It states: "The Medical Benefit is paid for Eligible Expense [sic] incurred for an Injury or Sickness while insured." And it defines an "Eligible Expense" as an expense "incurred for an Injury or Sickness while insured." Both provisions plainly refer to <u>expenses incurred</u> while insured, not <u>expenses arising from a sickness incurred</u> while insured. This reading is supported by the clause providing that an "'Expense' is deemed incurred on the date the

service or supply is furnished." If the Policy covered expenses incurred after termination, there would be no reason to specify the date on which an expense is incurred.

This interpretation is consistent with the Policy's "EXTENSION OF BENEFITS" provision. That provision sets forth limited circumstances under which a person may obtain benefits under the Policy even though the policy has been terminated. It states that Allstate will pay the Medical Benefit after the person's insurance ends if the person is totally disabled at the time the Policy is terminated and at the time the expense is incurred, the expense is directly related to the disability, and the expense is incurred within one year

of the termination. If, as Marsh claims, the Policy vested benefits, there would be no reason to include the "EXTENSION" provision because every expense it covers would be covered by vesting. In other words, the provision would be superfluous.

Considered together, these provisions would appear to preclude vesting. But Marsh points to another provision of the Policy that he claims vested his rights to benefits for any illness she contracted prior to the termination of the Policy. At the very least, he argues, this provisions cast doubt over those provisions of the Policy that preclude vesting, creating an ambiguity.

Marsh points to the provision in

the section of the Policy entitled "TERMINATION OF INSURANCE." It states: "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force." Marsh concludes that "loss" must refer to a sickness or injury that occurred while the policy was in effect. But Allstate responds that "loss" refers not to sickness but to "eligible expense." Read in isolation, "loss" could reasonably refer to either "sickness" or "expense"; the term is itself ambiguous. But precisely because of its ambiguity, it does not conflict with the provisions that preclude vesting. Read in light of the Policy's express limitation on the payment of medical benefits and the "EXTENDED COVERAGE" provision, the

ambiguity disappears and it becomes clear that "loss" refers to "expense". Thus the "TERMINATION" provision does not conflict with other portions of the Policy and does not render the Policy ambiguous.

IV

Finally, we conclude that nothing in the Policy implies that Marsh should receive the same benefits under the conversion policy as he did under the group policy. Marsh has pointed to nothing in the Policy that would have caused a reasonable person to draw such a conclusion. Nor has he offered any evidence that he held such a belief and relied on it.

V

Because we conclude that the Policy

unambiguously precludes the vesting of benefits, the decision of the district court is AFFIRMED.

APPENDIX B

No. 90-56143

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

ORDER

Before: BEEZER, HALL and TROTT, Circuit Judges

The panel has voted to deny appellant's petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing is DENIED and the suggestion for rehearing en banc is REJECTED.

APPENDIX C

29 U.S.C. section 1001:

CONGRESSIONAL FINDINGS AND DECLARATION OF POLICY

(a) **Benefit plans as affecting interstate commerce and the Federal taxing power**

The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment

and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that

disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees

and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) **Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries**

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of

participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts.

c. **Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance**

It is hereby further declared to be the policy of this chapter to protect

interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

APPENDIX D

No. CV 90-2145 RB (Ex)

in the

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant

ORDER GRANTING PRELIMINARY

INJUNCTION

This matter came to be heard upon Plaintiff Jonathan Marsh, a minor, by and through his Guardian ad litem, Sharon Marsh's Motion for Preliminary Injunction, as supported by the Complaint, the other pleadings, memoranda, declarations and exhibits filed in this case. The Court, having considered the pleadings and documents filed in this matter and the arguments of counsel, makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Plaintiff JONATHAN MARSH, the son of RICHARD V. MARSH and SHARON MARSH, was born September 29, 1978. On or about October 28, 1982, plaintiff suffered anoxic brain damage as the result of a

swimming pool drowning accident that has left plaintiff in a persistent vegetative stated, totally disabled, and dependet upon home health nurses to provide him with care, treatment and medical assistance.

2. At the time of the plaintiff's drowning accident, plaintiff was insured as a dependent of his father, RICHARD MARSH.

3. RICHARD MARSH is an employee of MARSH BROADCASTING, which company had joined in association with Universal Broadcasting Corporation ("UNIVERSAL") to procure health insurance for its employees.

4. Universal procured major medical and health insurance for its member-employers and their employees from

Equinet Small Group Network Trust, the policyholder of insurance underwritten by defendant Allstate Life Insurance Company of New York ("ALLSTATE").

5. Previously, similar policies of insurance had been underwritten by The Equitable Assurance Society of the United States and The Travelers Insurance Company.

6. Effective April 10, 1986, Allstate Life Insurance Company of New York ("ALLSTATE") assumed underwriting of the group plan through which plaintiff was insured, and continued to provide plaintiff coverage through May 1, 1989 when Allstate terminated the group coverage.

7. Pursuant to the "EXTENSION OF BENEFIT" provision, Allstate extended

benefits available under the group insurance policy for one year from the date of termination through expiration on May 1, 1990.

8. Allstate has offered to extend plaintiff an individual conversion policy, see Exhibit "C" at 24a, and although such benefits are not clearly defined, they are less comprehensive and are severely limited in medical coverage as compared with the benefits currently provided by Allstate through the extension of benefits policy.

10. [sic] Under the heading of TERMINATION OF INSURANCE: Dependents' Insurance, the subject insurance policy provides that "[t]he end of insurance will not affect any claim made for a loss that took place while the insurance

was in force. [sic] See Exhibit "C" at 8a of Plaintiff's Application for Temporary Restraining Order.

11. The financial inability of plaintiff's parents to meet the expenses incurred by plaintiff's health care costs, estimated at $325,000 annually, threatens the discontinuation of plaintiff's major medical and hospitalization coverage and individual nursing home care. See Declaration of Sharon Marsh, appended to Application for Temporary Restraining Order.

12. Without constant diagnostic monitoring, "round-the-clock" treatment, and supervision by skilled health care professionals, the loss of individual home nursing care risks endangering the plaintiff's physical and mental

condition. See Declaration of Carol Walker, M.D., appended to Application for Temporary Restraining Order.

CONCLUSIONS OF LAW

This Court has jurisdiction over the matter as plaintiff is a dependent under a group insurance policy issued to the employer of plaintiff's father. The group insurance policy is a benefit pursuant to a "benefit plan" as defined in 29 U.S.C. 1001, et seq., the Employee Retirement Income Security Act ("ERISA") and as interpreted by the United States Supreme Court in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987).

Plaintiff's application for a temporary injunction demonstrates that there are serious questions going to the

merits and that the balance of hardship tips sharply in his favor. Sierra Club v. March, 815 F.2d 1376, 1382 (9th Cir. 1987). See also Regents of the Univ. of Calif v. ABC, Inc., 747 F.2d 511, 515 (9th Cir. 1984) ("the greater the relative hardship to the moving party, the less probability of success must be shown").

Notwithstanding the applicability or breadth of ERISA's preemption (29 U.S.C. §514(a), in resolving claims that implicate a group health policy for employee welfare benefit plans, general principles of contract construction require that ambiguities in insurance contracts be construed against the insurer. Kunin v. Benefit Trust Life Insurance Co., 90 Daily Journal DAR

3073, 3076 (March 22, 1990).

The plain reading of the Allstate Policy language which provides that "[t]he end of insurance will not affect any claims made for loss that took place while the insurance was in force" is, at best, ambiguous and must be resolved against Allstate. [emphasis added]. See Gray v. Zurich Insurance Co., 65 Cal.2d 263, 271-72 (1966) (a policy provision is ambiguous when there are two or more reasonable interpretations or constructions of the policy language).

Reasonable interpretation of the above cited language means that termination of the insurance policy would not preclude recovery on claims arising out of a loss which occurred

during the pendency of the policy. Thus, in the case at bar, Allstate's termination of coverage in May 1989, would not affect plaintiff's rights to continue to receive medical care for the pre-existing medical condition from which plaintiff suffered consistent with the care he had been receiving while the policy was in force.

Allstate urges that the language in question states that nothing more than "expenses" incurred during the time the insurance policy is in force will be reimbursed even after termination. The Court is not persuaded to read the clause to effectuate that limitation. Specifically, the policy language with regard to the contested provision uses the term "loss." The dictionary

definition of the term "loss" as applied in insurance agreements means an injury that is the basis for a claim under the terms of the policy. Webster's New World Dictionary 799 (3d ed. 1988). Because the basis for plaintiff's claim is the injury sustained while the policy was in force, an insured could reasonably expect that continuous disability benefits relating to that loss are to be covered even after the termination of the policy.

The Court bases its conclusion without reaching the question whether the right to receive benefits "vests" at time of disability (and cannot be divested by subsequent termination of the policy) is applicable to the instant case. Instead, the Court's ruling is

based on the well-settled view that ambiguities in an insurance contract must be interpreted in the light most favorable to the insured, and that the language of an insurance contract should in fact 'be interpreted in accordance with the way it would be understood by the average man purchasing insurance.'" (Fields v. Blue Shield of California, 163 Cal.App.3d 570, 588 (1985).

Pending the trial in this matter, the Court ORDERS that ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK is prohibited from terminating and/or withholding and/or decreasing the policy benefits payable to the insured JONATHAN MARSH, under Group Policy No. 208748.

Pursuant to Fed. R. of Civ. Pr. 56(c), this Preliminary Injunction Order

shall issue and become effective upon the posting of security by plaintiff in the sum of $125,000.

Trial in this matter is set for September 25, 1990 at 9:30 a.m. Pretrial conference will be held September 17, 1990 at 3:00 p.m. The parties will have until September 17, 1990 to complete discovery in this action.

IT IS SO ORDERED

DATED: May 9, 1990

ROBERT C. BONNER
UNITED STATES DISTRICT JUDGE

APPENDIX E

No. 90-2145 RB (Ex)

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

MEMORANDUM OF DECISION AND ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT, GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DISSOLVING PRELIMINARY INJUNCTION ORDER

Introduction

On May 9, 1990 this Court granted a preliminary injunction enjoining Allstate Life Insurance Company of New York from terminating, withholding, or decreasing the policy benefits payable to the insured Jonathan Marsh, under Group Policy No. 208748. See Order Granting Preliminary Injunction filed May 9, 1990. Concurrent with the hearing setting security for the Preliminary Injunction, the Court also calendared these cross-motions for summary judgment to full adjudicate the rights and liabilities of the parties to this dispute.

This Court, having heard oral argument in this matter on July 30, 1990 and having considered the memoranda and

evidence submitted by counsel, concludes Allstate is entitled to summary judgment in its favor and plaintiff's motion for summary judgment is denied. Dissolution of the Preliminary Injunction Order, which has remained in effect since the July 30, 1990 hearing, is stayed for thirty (30) days from the entry of this Order.

Factual Background

Plaintiff, the dependent son of Richard V. Marsh, an employee of Marsh Broadcasting, suffered a near-drowning accident in October of 1982 that rendered him totally disabled. He is in a persistent vegetative state and dependent upon home health nurses to provide him with care, treatment, and

medical assistance. The plaintiff, a minor represented by his Guardian ad litem, his mother Sharon Marsh. At all times relevant to this action, Richard Marsh was an employee of Marsh Broadcasting, a company which had joined in association with defendant Universal Broadcasting Corporation to procure health insurance for its employees. Universal Broadcasting Corporation, in turn, had procured insurance for the employees of its members from defendant Equinet Small Group Network Trust.

At the time of plaintiff's accident in 1982, he was insured under a group policy issued by The Equitable Life Insurance. Subsequently, Equinet replaced the Equitable policy with Travelers, which itself was later

replaced with Allstate, effective April 10, 1986. However, Allstate did not actually begin providing benefits to plaintiff until January 1, 1988, because plaintiff was receiving benefits under an extension of benefits provision of the predecessor carrier's policy.

Allstate's liability for coverage to plaintiff extends to reimbursing medical expenses incurred while its Group Policy is in force. In addition, where a pre-existing condition is involved, Allstate pays benefits for a pre-existing condition that was covered while the prior policy was in force, but those benefits are also limited to medical expenses incurred during the period the Allstate Group Policy is in force. See Allstate Policy, at 20a and

29a.

Richard Marsh terminated coverage for himself and his dependents under the Allstate Group Policy on April 30, 1988 and elected to receive continuation benefits under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, Title 29 U.S.C. sections 1161-1168) until April 30, 1989 when that coverage was terminated by Mr. Marsh.[1]

Upon termination of plaintiff's COBRA coverage, Allstate, beginning on May 1, 1989, provided benefits to plaintiff under the "Extension of Benefits" provision of the Group Policy (18a).[2] The extension expired on May 1, 1990.

Mr. Marsh has elected to purchase an individual conversion policy, but

these benefits are less comprehensive than the benefits provided by Allstate under the group plan.[3]

When an insured terminates employment, as did Mr. Marsh, he is provided with a "Notice of Conversion Privilege for Group Medical Insurance," which, in part, states that "this conversion coverage is different from the benefits you had under the group plan." Exhibit A, appended to Allstate's moving papers.

Discussion

1. "Vesting" does not apply to Plaintiff's right to coverage for medical expense benefits under the Allstate Group Policy.

Plaintiff argues that he as a "vested" right to reimbursement of expenses incurred as a result of his

continued treatment for injuries sustained as a result of the 1982 accident. Plaintiff has not cited any authority that has ever incorporated the California state law concept of "vesting" into the ERISA context. However, this Court need not decide whether as a matter of federal common law vesting should ever apply under ERISA, because this doctrine does not help plaintiff under the facts and circumstances of the Allstate policy.

The general rule of vesting provides that "[a] valid cancellation of a group policy does not have the effect of releasing the insurer from liability which accrued prior thereto by reason of the happening of the contingency insured against. In other words, once liability

has attached under a group policy -- that is, after the happening of the event insured against -- cancellation of the policy is ineffective to preclude recovery by the beneficiary as provided by the original policy. This rule does not apply where there is an express provision in the policy to the contrary." See Annotation, 68 A.L.R.d 248, section 17 at 279 (Group Policy - Coverage Termination (1959)).

The concept of vesting is not germane to plaintiff's claim to continued reimbursement under Allstate's policy for two reasons. First, vesting is predicated on a "happening", that is, an "occurrence." Typically, vesting arises in an accidents or casualty policy. Allstate's duty to plaintiff,

however, derives from a "Medical Expense Benefits" policy where the triggering "event" is the accrual of a medical expense, e.g., for home care treatment.

Under medical expense insurance policies, an insured's right to benefits does not "vest" at the occurrence of an injury. Indeed, it would be illogical to hold plaintiff's rights "vested" with Allstate in 1982 (date of the accident) when, in point of fact, Allstate was not even the carrier at the time of plaintiff's accident. See Blue Cross of Florida v. Dysart, 340 So.2d 970 (Fla.App.2d Dist. 1976) (an extension of benefits for treatment related to injuries sustained while plaintiff was covered by Blue Cross did not apply to a policy of medical expenses insurance,

although it might apply to a policy of accident insurance, because accident policies generally contemplate converge for all expenses incurred as a result of an accident occurring within the policy period). Bartulis v. Metropolitian Life Insurance Company, 72 Ill.App.2d 267 (4th Dist. 1966) also resolved a similar type of duration of coverage issue on the basis of the insurance policy in question. The court held that the group hospitalization insurer was not liable for surgery after the policy period, although the injury occurred during the period of coverage, because the coverage was not for injuries during the policy period but for expenses incurred during the policy period.

> It seems crystal clear that the coverage provided was for

> confinement as a patient in a hospital and surgery performed while the policy was in force. Neither event occurred during the life of the policy. Neither in such provisions nor elsewhere in the policy is there language suggesting that the policy could or should be read as providing coverage for hospitalization or surgery resulting from injuries while the policy was in force. To so read this policy is to annex to it coverage neither specifically stated nor reasonably implied.

Id. at 226.

Second, the Allstate policy itself expressly limits benefits for expenses incurred while coverage is in force. In this regard, the "Medical Benefit" section provides payment for an "eligible expense incurred for an Injury or Sickness while insured" (12a), and the "Termination of Insurance" section provides that the end of insurance will

not be used to deny coverage for "a loss that took place while the insurance was in force" (7a). The Allstate policy, consequently, does not provide benefits for expenses incurred after termination of coverage, excepting the one-year post-termination period during which time the beneficiary is entitled to extended benefits. See Cohen v. Northwestern National Life Insurance, 124 Ill.App.2d 15 (1st Dist. 1970) (insurer was not held liable for charges incurred by the plaintiff's covered dependent after coverage terminated, even though the charges related to a condition diagnosed prior to cancellation of the group policy because policy provided coverage for medical expenses "if while insured under the

policy").

Finally, plaintiff's reliance on Fields v. Blue Shield of California, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (Cal.App.4th Dist. 1985) is misplaced. In Fields, the group health contract provided for a "lifetime maximum benefit payable for treatment of nervous and mental illness of $50,000." While the contract was still in force, it was modified to exclude coverage for psychological treatment that was used to obtain credit "toward earning degree." Fields, a physician who began psychoanalysis based on being diagnosed as a neurotic, decided to become a psychotherapist, and continued receiving psychoanalysis as part of his training requirement. Blue Cross invoked the

"furtherance of education" exclusion. In finding Blue Cross liable for reimbursement of expenses, the court held that the original contract "evidenced a clear contractual intent of Blue Cross to provide for nervous or mental illness which might persist for the lifetime of an insured" once treatment for a specific illness began. Id. at 585. Those benefits, up to the $50,000 lifetime maximum, became vested as matter of contractual right under the plan at issue. In addition, the court found the notice of modification provision was "clearly ambiguous" and in conflict with the original contract's unequivocal language permitting a lifetime maximum $50,000 grant. Id. at 584.

The Fields holding was based principally on the insurer's unilateral modification of the policy, a modification that contradicted the terms of the insured's insurance contract guaranteeing that "No such modification or termination will affect adversely any benefit for a covered service." Given the modification's ambiguity, the court invoked the settled view that "where a health insurance contract is susceptible to different reasonable constructions, it is ambiguous -- the insurance policy is to be strictly construed against the insurer. (Civ. Code section 1654)." Fields, supra, at 584-85.

The case at bar is unlike Fields where "modifications" to the scope of coverage, made while the policy was in

force, had the effect of reducing plaintiff's benefits. Dr. Fields had been and remained covered by the insurer, Blue Cross, at the time benefits were withheld; whereas, in the instant case, Mr. Marsh voluntarily terminated coverage and, therefore, under the terms of the policy, his dependent's rights to recover medical expense benefits.[4]

2. Kunin supplies the rule of contra proferentum in ERISA actions.

Allstate's Group Insurance Policy, issued to the employer of plaintiff's father, confers benefits pursuant to a "benefit plan" as defined in Title 29 U.S.C. 1001, et seq., the Employee Retirement Income Security Act ("ERISA") and as interpreted by the U. S. Supreme Court in Pilot Life Insurance Co. v

Dedeaux, 481 U.S. 41 (1987). Notwithstanding the applicability or breadth of ERISA's preemption (29 U.S.C. section 514(a)) in resolving claims that implicate a group health policy, general principles of contract construction mandate that "ambiguities in insurance contracts must be construed against the insurer." Kunin v. Benefit Trust Life Insurance Co., 90 Los Angeles Daily Journal D.A.R. 8450 (No. 88-6573 July 30, 1990). The Ninth Circuit unequivocally adopted this view, holding that the rule of contra proferentum applies to a group health and medical policy governed by ERISA.[5]

A typical statement of the rule, as explained in Kunin, is that if, after applying the normal principles of

contractual construction,

> the insurance contract is fairly susceptible of two different interpretations, another rule of construction will be applied: the interpretation that is most favorable to the insured will be adopted. The rule is based upon the principle of contract construction that when one party is responsible for the drafting of an instrument, absent evidence indicating the intention of the parties, any ambiguity will be resolved against the drafter.

Id. at 8450, citing A. Windt, Insurance Claims and Disputes section 6.02, at 281-82 (footnote omitted).

However, the ambiguity must affect the determination whether coverage should be denied. Where resolution of the ambiguity at issue would not arguably permit coverage under either of the two reasonable interpretations, the

insured cannot avail himself of this rule of construction.

3. The Allstate Group Policy does not provide benefits for plaintiff's medical expenses incurred after termination of the policy.

At the preliminary injunction proceeding, this Court found that the Allstate Policy language relating to the "Termination of Insurance" section (8a) -- "[t]he end of insurance will not affect any claim made for loss that took place while the insurance was in force" -- is ambiguous. Nowhere in the policy, for instance, including the extensive "Definitions" section, is te term "loss" defined.[6] There might be room for disagreement in certain

circumstances as to the limiting effect of the term "loss." However, for purposes of adjudicating the plaintiff's rights against Allstate in this case, the Court need not resolve that construction here. Notwithstanding the ambiguity of that clause, it is clear that plaintiff's rights are only ro reimbursement for a covered loss arising while the policy was in effect. Regardless of whether the term "loss" is construed to refer to the plaintiff's 1982 accident or his continuing medical expenses, neither occurred while the Allstate policy was in effect.

On the one hand, Allstate apparently claims "loss" refers to the round-the-clock home health care and medical expenses[7] incurred while the

policy is in force, that is, through April 30, 1990, including the one-year extension of benefits period. If this construction is operative, then, plaintiff is not covered for expenses incurred beyond the policy's termination, that is, for a loss (read expense) that did not take place <u>while</u> the insurance was in force.

Alternatively, the term "loss" can refer to plaintiff's 1982 swimming pool accident, but since that loss did not take place "while [Allstate] insurance was in force" -- indeed, it took place about 3 1/2 years before Allstate became the group carrier -- Allstate cannot be held liable to plaintiff under that usage of "loss." Plaintiff does not enjoy a "vested" right against Allstate

to coverage for continued treatment for injuries sustained as a result of an accident, for at the time of the 1982 accident Allstate was not on the risk. See Parrish v. National General Insurance Company, 731 S.W.2d 547 (Tenn. Ct. of App. 1987).

Finally, the plaintiff claims entitlement to continued coverage from Allstate based on the "Transfer of Insurers" section (20a). This section is relevant where, as here, the Employer's plan replaces another group medical expense plan. Allstate agrees to pay benefits for a pre-existing condition that was covered under the immediately prior policy of the insured, but limits benefits to the lesser amount of 1) the benefits of the Allstate plan

or 2) the benefits of the plan being replaced.

The purpose of this provision is to incorporate Insurance Code section 10128.3, ensuring that when one group policy replaces the immediately preceding group policy, the successor insurer may not withhold benefits for pre-existing conditions covered by the prior carrier, which, otherwise the successor insurer typically would exclude. It does not, however, mean that Allstate assumes or succeeds to an unlimited coverage obligation after terminating and cessation of premium payments for a condition that may have accrued with respect to the prior carrier. That is, benefits that might or might not arguably have been "vested"

under a predecessor policy are not transferred from one insurance carrier to another on the basis of this provision.

4. Plaintiff is not entitled to the Same Level of Benefits under the Conversion Policy as provided under the Group Policy.

Plaintiff contends that he is entitled to the same level and extent of benefits under the Conversion Policy (24a) as he received pursuant to the Group Policy. As a matter of statutory requirement, Insurance Code sections 12670 and 12684 ensure that conversion policies satisfy a certain level of "minimum benefits" with which Allstate has complied.

Plaintiff's father, Mr. Marsh, asserts that he was under the impression his son would receive the comparable benefits as provided under the group plan, because the policy stated "the form, benefits provided, premiums and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." (24a) Allstate provided Mr. Marsh with detailed information regarding the amount of conversion coverage available at his request. Decl. of Elizabeth Townsend, appended to Allstate's moving papers. In response, plaintiff has not provided any rebuttal evidence to support the [sic] Mr. Marsh's suggestion that he was misled into thinking the individual policy would ba as

comprehensive as the group policy. Indeed, Mr. Marsh's belief that expenses incurred on behalf of his son would remain covered was based on his understanding of the "Termination of Insurance" clause. Marsh Decl. at para. 4 & 5, appended to Plaintiff's moving papers. Accordingly, it appears that Mr. Marsh was not even relying on the "Transfer of Insurers" section when he elected to terminate his COBRA coverage, and opted for the individual conversion package of benefits.

In any event, the "Transfer of Insurers" section does not operate to "vest" coverage as against the successor carrier for claims concerning a pre-existing condition that arose during the term of a prior carrier's policy.

Conclusion

Based on the foregoing reasons, IT IS ORDERED that Allstate's motion for summary judgment is granted and plaintiff's motion for summary judgment is denied.

IT IS FURTHER ORDERED that the Preliminary Injunction Order shall be dissolved effective thirty (30) days from the entry of this Order.

Counsel for Allstate is directed to lodge within ten (10) days from the entry of this Order a proposed form of judgment.

IT IS SO ORDERED

DATED: AUGUST 10, 1990

ROBERT C. BONNER
UNITED STATES DISTRICT JUDGE

1. It appears Mr. Marsh was entitled to continuation of benefits under COBRA for 18 months post-termination, that is, until October 30, 1989. Title 29 U.S.C. section 1162 (individual may elect up to 18 months of COBRA continuation coverage).

2. The "Extension of Benefit" section provides that Allstate will pay the Medical Benefit after a person's insurance ends if, inter alia; 1) the person is totally disabled on the day the insurance ends and 2) the expense is incurred within 12 months after the day insurance ends. These conditions are satisfied in the instant case.

3. The Group Policy provides that: "A person whose medical Expense Insurance ends may be eligible to buy health insurance coverage from us. . . The form, benefits provided, premium and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." (24a) of the Group Policy.

4. In fact, Fields observes that courts which have declined to invoke the doctrine of "vesting" involved insurance policies which, as in the case a bar, "had been terminated before the insured incurred the medical expenses, before the vesting occurred." Id. at n. 7. This reasoning undermines plaintiff's view that benefits for medical expenses incurred after the Allstate policy

terminated had already "vested."

5. However, Kunin's amended opinion cannot be read to suggest, as plaintiff, urges, that California law regarding vesting, even if applicable to the facts at bar, applied to ERISA actions. As Kunin stated, "Of course, neither the law of California nor that of any other state is applicable here of its own force." And, although the opinion noted that "State law can sometimes control [ERISA] controversies," id. at 8450, the panel specifically declined to incorporate any state of California rule of construction into federal common law, because it explicitly held that the contra proferentum rule is "followed in all fifty states and the District of Columbia." Id.

6. The only other occasion where the term "loss" appears in the Accidental Death and Dismemberment Benefit section (10a) which is "For Employees Only." It provides for insurance against a loss of life or limb that results from an accident that takes place while insured by this benefit and within 90 days after the accident. The usage here supports the position that "loss" refers to the event or triggering injury necessitating the medical care, rather than the reimbursement of plaintiff's medical expense benefits. Under this view, the "loss" involved here occurred in 1982, about 3 1/2 years before Allstate assumed coverage for the group health

plan.

7. The Group Policy provides that "[t]he Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured." (12a of the Policy). "Eligible Expense" is defined as meaning "the following types of Expense incurred for an Injury or Sickness while insured . . . " (14a) Expense is defined as "a charge a person is legally obligated to pay. Expense is deemed to be incurred on the date the service or supply is furnished . . . " (25a).